DeltaCare®
Administered by Delta Dental of Washington

03100 State Managed Care Plan

Delta Dental of Washington

Effective: **January 1, 2015**

SAVE THIS BOOKLET FOR REFERENCE

This booklet explains benefit provisions that are specific to a dental plan administered by the Washington State Health Care Authority. This booklet, which explains program eligibility and general provisions, constitutes the certificate of coverage for enrollees in this dental plan. This certificate of coverage replaces and supersedes any and all previous certificates.

It is your responsibility to be informed about your benefits. To avoid penalty or loss of benefits, please note all plan predetermination requirements, service area restrictions and benefit limitations. If provisions within this booklet are inconsistent with any federal or state statute or rules, the language of the statute or rule will have precedence over that contained in this publication.

This booklet was compiled by the Washington State Health Care Authority, P.O. Box 42682, Olympia, Washington 98504-2682. If you have questions on the provisions contained in this booklet, please contact the dental plan.

Certificate of Coverage

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This booklet sets forth in summary form an explanation of the coverage available under your dental plan.

For customer service, call the
Delta Dental of Washington DeltaCare® Client Services Team
At 1-800-650-1583

DeltaCare®, a managed care dental plan
Administered by Delta Dental of Washington

Introduction

Welcome to the DeltaCare® Plan, which is administered by Delta Dental of Washington (DDWA), the state's largest and most experienced dental benefits carrier. DDWA is a member of the nationwide Delta Dental Plans Association. With a Delta Dental Plan from DDWA, you join more than 50 million people across the nation who have discovered the value of our coverage. This benefit booklet is your Certificate of Coverage and sets forth, in summary form, an explanation of the coverage available under your dental plan.

Terms Used in This Booklet

Appeal: An appeal is a written or oral request from an enrollee or, if authorized by the enrollee, the enrollee's representative to change a previous decision made by Delta Dental of Washington concerning: a) access to dental care benefits, including an adverse determination made pursuant to utilization review; b) claims handling, payment, or reimbursement for dental care and services; c) matters pertaining to the contractual relationship between an enrollee and Delta Dental of Washington or d) other matters as specifically required by state law or regulation.

Copayment: The dollar amount enrollees pay when receiving specific services.

Dental Emergency: The emergent and acute onset of a symptom or symptoms, including severe pain that would lead a prudent layperson acting reasonably to believe that a dental condition exists that requires immediate dental attention.

Dental Necessity: A service is "dentally necessary" if it is recommended by the treating provider and if all of the following conditions are met.

Necessary vs. Not Covered Treatment — You and your provider should discuss which services may not be covered dental benefits. Not all necessary treatment is covered, and there may be additional charges. The majority of required dental services are covered by your plan. However, there are certain treatments that remain the responsibility of the patient.

1. The purpose of the service, supply or intervention is to treat a dental condition;

2. It is the appropriate level of service, supply or intervention considering the potential benefits and harm to the patient;

3. The level of service, supply or intervention is known to be effective in improving health outcomes;

4. The level of service, supply or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention; and

5. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

- A health "intervention" is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a dental condition (i.e., disease, illness, injury, genetic or congenital defect or a biological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of "dental necessity," a health intervention means not only the intervention itself, but also the dental condition and patient indications for which it is being applied.
- "Effective" means that the intervention, supply or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

- An intervention, supply or level of service may be dentally indicated, yet not be a covered benefit or meet the standards of this definition of “dental necessity.” DDWA may choose to cover interventions, supplies, or services that do not meet this definition of “dental necessity,” however, DDWA is not required to do so.
- “Treating provider” means a health care provider who has personally evaluated the patient.
- “Health outcomes” are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.
- An intervention is considered to be new if it is not yet in widespread use for the dental condition and patient indications being considered.
- “New interventions” for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion (See “existing interventions” below).
- “Scientific evidence” consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.
- For “existing interventions,” the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of “dental necessity.” If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet DDWA’s definition of “dental necessity” in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.
- A level of service, supply or intervention is considered “cost effective” if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative. Cost-effective does not necessarily mean lowest price.

Dependent: Eligible dependent covered under the enrollee.

Enrollee: The employee or retiree enrolled in this plan.

Experimental or Investigative: A service or supply that is determined by DeltaCare to meet any one of the following criteria. If any of these situations are met, the service or supply is considered experimental and/or investigative, and benefits will not be provided.

a. It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA), and such approval has not been granted on the date it is furnished.

b. The provider has not demonstrated proficiency in the service, based on knowledge, training, experience and treatment outcomes.

c. Reliable evidence shows the service is the subject of ongoing clinical trials to determine its safety or effectiveness.

d. Reliable evidence has shown the service is not as safe or effective for a particular dental condition compared to other generally available services and that it poses a significant risk to the enrollee’s health or safety.

e. Reliable evidence means only published reports and articles in authoritative dental and scientific literature, scientific results of the provider's written protocols or scientific data from another provider studying the same service.
f. The documentation used to establish the plan criteria will be made available for enrollees to examine at the office of DeltaCare if enrollees send written requests.
g. If DeltaCare determines that a service is experimental or investigative, and therefore not covered, the enrollee may appeal the decision. DeltaCare will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with the enrollee's informed written consent.

Group: The employer or entity that is contracting for dental benefits for its employees.

HCA: Health Care Authority.

Licensed Professional: An individual legally authorized to perform services as defined in his/her license. Licensed professional includes, but is not limited to, denturist, hygienist and radiology technician.

Member: Enrollee or dependent, who has completed the enrollment process.

Plan: DeltaCare, a managed dental benefit plan of coverage.

Plan Designated Facility or Dentist: A licensed dentist or dental facility that has agreed to perform services under this plan.

Primary Care Dentist: Dentist or facility that enrollee or dependent has selected.

Subscriber: Eligible employee or retiree who has completed the enrollment process and is enrolled in this dental plan.

Retiree Participation

Retirees must be enrolled in a medical plan to be eligible to enroll in the dental plan. If retirees enroll in the medical and dental plans, they must enroll the same eligible dependents under both plans. Once enrolled in the medical and dental package, retirees cannot change to "medical-only" for at least two years. The two-year requirement does not apply to retirees whose medical and dental coverage is terminated due to the retiree's return to employment and subsequent enrollment in active group coverage, including spouses' re-employment.

Choosing a Primary Care Dentist (PCP)

When you enroll in the DeltaCare Dental Plan, you must complete the enrollment information and may indicate your dental office choices at that time. New enrollees have 60 days to select and notify us of your preferred Primary Care Provider (PCP). A PCP is a Washington state General Practitioner that has chosen to participate in the DeltaCare Network.

If you do not select a PCP within 60 days, we will assign you to a provider near your home. The choice of PCP can be changed with proper notice to DDWA, but participation in the plan must continue at least until the next open enrollment period. Please contact us at 1-800-650-1583 for more information on selecting or changing your PCP or to notify us of your selection.

Your selected dental office is now the center for all of your dental needs. The PCP will perform most dental services. For specialty care, the PCP may elect to refer treatment to a DeltaCare Dental Plan Specialist.

After you have enrolled, you will receive a membership card and letter. The letter will include the address and telephone number of your PCP.

If your PCPs participation in the DeltaCare Network is terminated, you will receive written notification.. This notification will explain your option to: 1) automatically be assigned to another PCP; or 2) select another PCP from the directory of open PCPs. If your PCP is to be absent for an extended period of time, you may transfer to another PCP dentist during the period of the absence.

Appointments

To receive dental care, simply call your primary care dental office to make an appointment. Routine, non-emergency appointments will be scheduled within 3 weeks of the date of the request. Dental services which are not performed by the assigned DeltaCare Dental Plan office or properly referred to a DeltaCare Dental Plan Specialist will not be covered by the DeltaCare Dental Plan.

Specialty Services

Your PCP is responsible for coordinating all specialty care and will either perform the specialty treatment or refer you to a DeltaCare Network Specialist. In some unique cases the PCP may refer you to a non-DeltaCare Network Specialist, but prior authorization from DDWA is required.

Urgent Care

Your PCP shall provide urgent dental care for a covered procedure within 24 hours of being contacted. If an Enrollee requires urgent dental care and is not able to be seen by their PCP within 24 hours or is not within a reasonable distance of their PCP's office, the enrollee may receive treatment from another dentist. Such treatment is limited to the treatment that is necessary to evaluate and stabilize the enrollee until they can obtain further treatment from their assigned dentist.

The Plan shall reimburse the Enrollee for the cost of such urgent dental care which exceeds the enrollee's Co-payment up to a $100 maximum per calendar year. In cases where immediate additional care beyond stabilization and palliative treatment is medically required, DDWA will carefully review and consider additional reimbursable coverage beyond the $100 maximum according to the standard list of covered benefits under the plan.

Emergency Care

DeltaCare Network dentists have made provisions for delivering emergency care. Emergency care is available 24 hours a day, every day of the year. Treatment of a dental emergency, those rare dental health instances that may be life threatening or cause severe bodily injury, shall not require a predetermination if a prudent layperson acting reasonably would believe that such an emergency condition exists. The Plan would encourage the enrollee to seek a preauthorization from the Plan for such emergency care if at all practical, but would not require preauthorization if the treatment is a listed procedure under the terms of coverage. You should notify DeltaCare after receiving emergency dental care within 15 days, or when practical, as to the extent of such emergency dental treatment.

Benefit Period

Most dental benefits are calculated within a "benefit period," which is typically for one year. For this plan, the benefit period is the 12-month period starting the first day of the calendar month, January and ending the last day of the calendar month, December.

Communication Access Assistance

For Individuals who are Deaf, Hard of Hearing, Deaf-blind or Speech-disabled

Communications with DDWA for people who are deaf, hard of hearing, deaf-blind and/or speech disabled is available through Washington Relay Service. This is a free telecommunications relay service provided by the Washington State Office of the Deaf and Hard of Hearing.

The relay service allows individuals who use a Teletypewriter (TTY) to communicate with DDWA through specially trained communications assistants.

Anyone wishing to use Washington Relay Service can simply dial 711 (the statewide telephone relay number) or 1-800-833-6384 to connect with a communications assistant. Ask the communications assistant to dial DDWA Customer Service at 1-800-554-1907. The communications assistant will then relay the conversation between you and the DDWA customer service representative.

This service is free of charge in local calling areas. Calls can be made anywhere in the world, 24 hours a day, 365 days a year, with no restrictions on the number, length or type of calls. All calls are confidential, and no records of any conversation are maintained.

Predetermination (estimate) of Benefits

For treatment that requires predetermination (see covered benefits section), the primary care dentist or specialist submits a claim form prior to commencing treatment. DeltaCare notifies the dentist of the level of coverage for all treatment submitted. Predeterminations are honored for up to six months from the issue date. Please check with your dentist for the benefit payment amount on the predetermination.

Schedule of Benefits and Co-Payments

Please see the following table which describes the Benefits and Co-Payments for this Plan. The Benefits and Co-Payments listed below are Effective as of **January 1, 2015.**

Schedule of Benefits and Co-Payments

The services covered under the DeltaCare Dental Plan are listed in the following schedule. These co-payments are your total price, including lab work. All coverage is subject to the exclusions and limitations set forth in the benefit descriptions and exclusions.

Procedure	Description	Copayment	Notes
D0100 - D0999	**I. Diagnostic**		
D0120	Periodic oral evaluation – established patient	0	
D0125	Failed appointment w/o 24 hr notice per 15 min appt time (not to exceed $25)	10*	
D0140	Limited oral evaluation-problem focused	0	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0	
D0150	Comprehensive oral evaluation - new or established (inactive) patient	0	
D0160	Detailed and extensive oral evaluation - Problem focused, by report	0	
D0170	Re-evaluation-limited, problem focused (Established pt not post op visit)	0	
D0180	Comprehensive Periodontal Exam – GP	0	
	Copay for Specialist Exam - use above codes	0	R
D0210	Intraoral - complete series of radiographic images	0	
D0220	Intraoral - periapical first radiographic image	0	
D0230	Intraoral - periapical each additional radiographic image	0	
D0240	Intraoral - occlusal radiographic image	0	
D0270	Bitewing - single radiographic image	0	
D0272	Bitewings - two radiographic images	0	
D0273	Bitewings - three radiographic images	0	
D0274	Bitewings - four radiographic images	0	
D0330	Panoramic radiographic image	0	
D0460	Pulp vitality tests	0	
D0470	Diagnostic casts	0	
D1000 – D1999	**I. Preventative**		
D1110	Prophylaxis cleaning - adult	0	
D1120	Prophylaxis cleaning - child	0	
D1206	topical application of fluoride varnish	0	
D1208	topical application of fluoride – excluding varnish	0	
D1330	Oral hygiene instructions	0	
D1351	Sealant - per tooth	0	
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	0	
D1510	Space maintainer - fixed, unilateral	20	

Procedure	Description	Copayment	Notes
D1515	Space maintainer - fixed, bilateral	30	
D1520	Space maintainer - removable, unilateral	20	
D1525	Space maintainer - removable, bilateral	30	
D1550	Recementation of space maintainer	10	
D1555	Removal of fixed space maintainer	10	
D2000 – D2335	**III. Minor Restorative**		
D2140	Amalgam - one surface, primary or permanent	10	
D2150	Amalgam - two surfaces, primary or permanent	10	
D2160	Amalgam - three surfaces, primary or permanent	10	
D2161	Amalgam - four or more surfaces, primary or permanent	10	
D2330	Resin-based composite - one surface, anterior	15	
D2331	Resin-based composite - two surfaces, anterior	15	
D2332	Resin-based composite - three surfaces, anterior	15	
D2335	Resin-based composite - four or more surfaces or involving incisal angle	15	
D2391	Resin-based composite - one surface, posterior	50	
D2392	Resin-based composite - two surfaces, posterior	50	
D2393	Resin-based composite - three surface, posterior	50	
D2394	Resin-based composite - four or more surfaces, posterior	50	
D2510 – D2999	**IV. Major Restorative**		
D2510	Inlay - metallic - one surface	115	
D2520	Inlay - metallic - two surfaces	115	
D2530	Inlay - metallic - three surfaces	115	
D2543	Onlay - metallic - three surfaces	125	
D2544	Onlay metallic - four or more surfaces	125	
D2740	Crown - porcelain/ceramic substrate	155	
D2750	Crown - porcelain fused to high noble metal	175	
D2751	Crown - porcelain fused to predominantly base metal	125	
D2752	Crown - porcelain fused to noble metal	150	
D2790	Crown - full cast high noble metal	175	
D2791	Crown - full cast predominantly base metal	125	
D2792	Crown - full cast noble metal	150	
D2794	Crown - titanium	OP	
D2799	Provisional crown	OP	
D2910	Recement or rebond inlay, onlay, veneer or partial coverage restorations	0	
D2915	Re-cement or rebond indirectly fabricated or prefabricated post and core	0	
D2920	Re-cement or rebond crown	0	
D2921	Reattachment of tooth fragment, incisal edge or cusp	15	
D2930	Prefabricated stainless steel crown - primary tooth	100	
D2931	Prefabricated stainless steel crown - permanent tooth	100	
D2932	Prefabricated resin crown anterior teeth only	100	Gap
D2940	Sedative filling	20	
D2941	Restorative foundation for an indirect restoration	20	

Procedure	Description	Copayment	Notes
D2950	Crown build-up (substructure) including any pins when required	0	
D2951	Pin retention - per tooth, in addition to restoration	0	
D2952	Post and core in addition to crown, indirectly fabricated	0	
D2953	Each additional indirectly fabricated post – same tooth	0	
D2954	Prefabricated post and core in addition to crown	0	
D2957	Each additional prefabricated post - same tooth	0	
D2970	Temporary crown (fractured tooth)	15	
D2971	Additional procedures to construct new crown under existing partial denture framework	0	
D2980	Crown repair necessitated by restorative material failure	30	
D2981	Inlay repair necessitated by restorative material failure	30	
D2982	Onlay repair necessitated by restorative material failure	30	
D2983	Veneer repair necessitated by restorative material failure	30	
D3000 - D3999	**V. Endodontics**		
D3110	Pulp cap-direct (excluding final restoration)	0	
D3120	Pulp cap-indirect (excluding final restoration)	0	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp	0	
D3221	Gross pulpal debridement, primary and permanent teeth	NB	
D3230	Pulpal therapy(resorbable filling, primary tooth(exclude final restoration)	NB	
D3240	Pulpal therapy(resorbable filling, primary tooth(exclude final restoration)	NB	
D3310	Root canal therapy - anterior (excluding final restoration)	100	
D3320	Root canal therapy - bicuspid (excluding final restoration)	125	
D3330	Root canal therapy - molar (excluding final restoration)	150	R
D3346	Retreatment of previous root canal therapy - anterior	100	R
D3347	Retreatment of previous root canal therapy - bicuspid	125	R
D3348	Retreatment of previous root canal therapy - molar	150	R
D3351	ation/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, pulp space disinfection, etc.)	10	R
D3352	Apexification/recalcification - interim visit	10	R
D3353	Apexification/recalcification - final visit	10	R
D3410	Apicoectomy - anterior	70	R
D3421	Apicoectomy - bicuspid	50	R
D3425	Apicoectomy molar (1st root)	100	R
D3426	Apicoectomy (additional root)	25	R
D3427	Periradicular surgery without apicoectomy	35	
D3428	Bone graft in conjunction with periradicular surgery – per tooth; first surgical site	100	
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	50	
D3430	Retrograde filling - per root	5	R
D3450	Root amputation - per root	0	R
D3920	Hemisection including root removal	0	R
D4000 - D4999	**VI. Periodontics**		

Procedure	Description	Copayment	Notes
D4210	Gingivectomy or gingivoplasty - four or more teeth per quadrant	75	
D4211	Gingivectomy or gingivoplasty - one to three teeth per quadrant	35	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure; per tooth	35	
D4240	Gingival flap procedure - allowed only in conjunction with D4263/D4264	0	R
D4241	Gingival flap procedure - allowed only in conjunction with D4263/D4264	0	R
D4245	Apically positioned flap	0	R
D4249	Crown lengthening - hard/soft tissue	35	R
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more Contiguous teeth or tooth bounded spaces per quadrant	100	R
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	75	R
D4263	Bone replacement Graft - first site in quadrant	100	R
D4264	Bone replacement Graft - each additional site in quadrant	50	R
D4270	Pedicle soft tissue graft procedure	100	R
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	50	
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft	25	
D4341	Periodontal root planing - four or more teeth per quadrant	35	
D4342	Periodontal root planing - one to three teeth per quadrant	15	
D4355	Full Mouth debridement, once every 12months	25	
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	0	R
D4910	Periodontal maintenance following active therapy	35	
D5000 - D5899	**VII. Prosthodontics, removable**		
D5110	Complete denture, maxillary	140	
D5120	Complete denture, mandibular	140	
D5130	Immediate denture, maxillary	140	
D5140	Immediate denture, mandibular	140	
D5211	Maxillary partial denture, resin base	140	GAP
D5212	Mandibular partial denture, resin base	140	GAP
D5213	Maxillary partial denture - metal base with resin saddles	140	
D5214	Mandibular partial denture - metal base with resin saddles	140	
D5225	Maxillary partial denture - flexible base	OP	
D5226	Mandibular partial denture - flexible base	OP	
D5410	Adjust complete denture - maxillary	0	
D5411	Adjust complete denture - mandibular	0	
D5421	Adjust partial denture - maxillary	0	
D5422	Adjust partial denture - mandibular	0	
D5510	Repair broken complete denture base	15	

Procedure	Description	Copayment	Notes
D5520	Replace missing or broken teeth - complete denture	15	
D5610	Repair resin saddle or base	15	
D5620	Repair cast framework	45	
D5630	Repair or replace broken clasp	30	
D5640	Replace broken teeth - per tooth	10	
D5650	Add tooth to existing partial denture	20	
D5660	Add clasp to existing partial denture	20	
D5670	Replace teeth and acrylic on cast metal framework (mandibular)	NB	
D5671	Replace teeth and acrylic on cast metal framework (maxillary)	NB	
D5710	Rebase complete maxillary denture	60	
D5711	Rebase complete mandibular denture	60	
D5720	Rebase maxillary partial denture	40	
D5721	Rebase mandibular partial denture	40	
D5730	Reline complete maxillary denture (chairside)	40	
D5731	Reline complete mandibular denture (chairside)	40	
D5740	Reline maxillary partial denture (chairside)	40	
D5741	Reline mandibular partial denture (chairside)	40	
D5750	Reline complete maxillary denture (laboratory)	50	
D5751	Reline complete mandibular denture (laboratory)	50	
D5760	Reline maxillary partial denture (laboratory)	50	
D5761	Reline mandibular partial denture (laboratory)	50	
D5850	Tissue conditioning, maxillary	15	
D5851	Tissue conditioning, mandibular	15	
D5863	Overdenture - complete upper	175	
D5864	Overdenture - partial upper	175	
D5865	Overdenture - complete lower	175	
D5866	Overdenture - partial lower	175	
D6000-D6199	**VIII. Implant Services**		
	Pre-Implant Consultation Fees	25	R
	Initial Implant Exam or Consultation		
	Detailed and Extensive Oral Evaluation	125	R
	Implant Fees - Case Rates		
	Single Tooth	2,800	R
	Two Teeth	5,464	R
	Three Teeth	7,644	R
	Full Denture (two implants)	5,120	R
	Full Denture (three implants)	6,885	R
	Each additional tooth	2,095	R
6102	Debridement of a periimplant defect;or defects surrounding a single implant and surface cleaning includes surface cleaning of the exposed implant surfaces including flap entry and closure	75	

Procedure	Description	Copayment	Notes
6103	Bone graft for repair of periimplant defect; does not include flap entry and closure.Placement of a barrier membrane or biologic materials to add in osseous regeneration are reported seperately	100	
D6200 - D6999	**IX. Prosthodontics, Fixed**		
D6210	Pontic - cast high noble metal	175	
D6211	Pontic - cast predominantly base metal	125	
D6212	Pontic - cast noble metal	150	
D6240	Pontic - porcelain fused to high noble metal	175	
D6241	Pontic - porcelain fused to predominantly base metal	125	
D6242	Pontic - porcelain fused to noble metal	150	
D6251	Pontic - resin with predominantly base metal	150	
D6252	Pontic - resin with noble metal	OP	
D6750	Crown - porcelain fused to high noble metal	175	
D6751	Crown - porcelain fused to predominantly base metal	125	
D6752	Crown - porcelain fused to noble metal	150	
D6780	Crown - 3/4 cast high noble metal	175	
D6790	Crown - full cast high noble metal	175	
D6791	Crown - full cast predominantly base metal	120	
D6792	Crown - full cast noble metal	150	
D6930	Re-cement or rebond fixed partial denture	0	
D6940	Stress breaker	65	
D6980	Fixed partial denture repair necessitated by restorative material failure	NB	
D7000 - D7999	**X. Oral Surgery**		
D7111	Extraction, coronal remnants - deciduous tooth	10	
D7140	Extraction, erupted tooth or exposed root	10	
D7210	Surgical removal of erupted tooth	10	
D7220	Removal of impacted tooth - soft tissue	30	R
D7230	Removal of impacted tooth - partially bony	40	R
D7240	Removal of impacted tooth - completely bony	50	R
D7241	Removal of impacted tooth-completely bony w/complications	50	R
D7250	Surgical removal of residual tooth roots	50	R
D7280	Surgical exposure impacted/unerupted tooth - ortho	15	R
D7283	Placement of device to facilitate eruption of impacted tooth	15	R
D7286	Incisional biopsy of oral tissue-soft	0	R
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces – per quadrant	0	
D7311	Alveoloplasty in conj. With extractions - one to three teeth per quad	0	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces – per quadrant	0	
D7321	Alveoloplasty not in conj. With extractions - one to three teeth per quad	0	
D7340	Vestibuloplasty	NB	R
D7350	Vestibuloplasty - ridge extension	NB	R
D7471	Removal of exostosis - maxilla or mandible	0	R

Procedure	Description	Copayment	Notes
D7472	Removal of torus palatinus	0	R
D7473	Removal of torus mandibularis	0	R
D7510	Incision and drainage of abscess	0	R
D7960	Frenulectomy (frenectomy or frenotomy)	20	R
D7970	Excision of hyperplastic tissue - per arch	30	R
D8000 - D8999	**XI. Orthodontic Services**		
D8660	Initial orthodontic diagnostic work-up and X-rays	50	
D8070	Full Orthodontic Services	1500	
	Limited Orthodontic treatment of the primary dentition	Prorated	
	Limited Orthodontic treatment of the transitional dentition	Prorated	
	Limited Orthodontic treatment of the adolescent dentition	Prorated	
	Limited Orthodontic treatment of the adult dentition	Prorated	
	Final orthodontic diagnosis, work-up and X-rays	Included	
	Lost metal bands or loose brackets	*	
	* see orthodontic benefits per plan		
	Orthognathic Surgery	Lifetime max $5000	
	Orthognathic surgery	Pre-determination	
	Temporomandibular Joint Treatment	Lifetime max $5000	
	TMJ consultation	30	
	TMJ treatment	Pre-determination	
D9000 - D9999	**XII. Additional Procedures**		
D9110	Palliative treatment	15	
D9211	Regional block anesthesia	0	
D9212	Trigeminal division block anesthesia	0	
D9215	Local anesthesia	0	
D9220	general anesthesia: up to 30 minutes (see General Exclusion, bullet #1)	50	R
D9241	Intravenous moderate (conscious) sedation anesthesia: up to 30 minutes (see General Exclusion, bullet #1)	50	R
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0	
D9440	Office visit - after regularly scheduled hours (nights and weekends)	20	
D9940	Occlusal guards by report	50	
D9951	Occlusal adjustment - limited	35	
D9952	Occlusal adjustment - complete	50	
D9986			
D9987			

P	**= Predetermination recommended**
R	**= Referable to a specialist**
GAP	**= Guidelines apply**

NB	**= Not a Benefit on plan**
OP	**= Optional Treatment**

Unlisted dental procedures and treatments that are not specifically excluded will be assigned copayments consistent with those above, based upon comparative complexity and cost.

Basic Benefits

The following basic benefits will be covered subject to the copayment amounts:

1. Oral Examination - Exam of the mouth and teeth.
2. Prophylaxis - Cleaning, scaling and polishing of teeth.
3. Topical Fluoride Application - Applying fluoride to the exposed tooth surface.
4. Periapical and Bitewing X-rays - Dental X-rays of the inside of the mouth. Periapical X-rays reveal the entire tooth and surrounding bone and gum tissue. Bitewing X-rays reveal some of the upper and lower teeth in the same film.
5. Extractions - The surgical removal or pulling of teeth.
6. Fillings - Silver amalgam, resin based composites or Silicate or plastic restorative material is covered.
7. Palliative Emergency Treatment - Emergency treatment primarily for relief, not cure.
8. Space Maintainers - An appliance to preserve the space between teeth caused by premature loss of a primary tooth. The primary teeth are the first teeth, sometimes known as baby teeth.
9. Repair of Dentures and Bridges - Repair or reline artificial teeth.
10. Oral Surgery - Surgery for dental purposes pertaining to the gums, teeth or tooth structure and treatment of dislocations.
11. Apicoectomy - Surgical removal of the tip of the tooth root.
12. Endodontics - The prevention, diagnosis, and treatment of diseases and injuries of the tooth pulp, root and surrounding tissue. This includes pulpotomy, pulp capping and root canal treatment.
13. Periodontic Services and Periodontic Maintenance Procedures Services related to connective tissues around and supporting the teeth; surgical periodontic exams, gingival curettage, gingivectomy, osseous surgery including flap entry and closure, mucogingivoplastic surgery, frenectomy, periodontal grafts, root planing and curettage, and management of acute infection and oral lesions related to the tooth structure.

Prosthodontic Services

Dentures, bridges, partial dentures, related items — including crowns placed on dental implants — and the adjustment or repair of an existing prosthetic device are covered under this benefit.

Replacement of missing teeth with full or partial dentures, crowns or bridges is limited to the charge for the standard procedure.

These services do not include and do not cover:

1. Personalized restoration, precision attachments and special techniques.
2. Replacement of an existing denture, crown or bridge less than five years after the date of the most recent placement.
3. Denture replacements made necessary by loss, theft or breakage.

Implant Services

Dental implant Services are now available to PEBB members enrolled in the DeltaCare Dental Plan offered by Delta Dental of Washington. Implant Services will be available at select dental offices experienced in providing dental implants. Implant Services will not be available at every participating DeltaCare dental office location.

Enrollees who have been determined by their Primary Care Provider to be candidates for dental implants will be referred to the nearest select dental office trained in the surgical placement of implants.

Delta Dental of Washington strongly suggests that any implant services be submitted to Delta Dental of Washington for predetermination prior to commencement of treatment.

Initial Implant Exam or Consultation is subject to a copayment by the subscriber. However, should the enrollee or an enrolled dependent initiate implant services at the office performing the initial Implant Exam or Consultation, the copayment for the Initial Implant Exam or Consultation will be deducted from the copayment of the implant service provided.

Orthodontic Services

Delta Dental of Washington strongly suggests that orthodontic treatment be submitted to, and predetermined by, DDWA prior to commencement of treatment.

Initial orthodontic diagnostic work-up and X-rays are subject to a copayment. However, should the enrollee or an enrolled dependent undergo orthodontic treatment, the initial orthodontia copayment will be deducted from either the partial or full orthodontia copayment.

The copayment for limited orthodontic treatment will be prorated according to the extent of orthodontia services provided. The length of treatment of full orthodontic treatment is not limited. Orthodontic treatment must be provided by a DeltaCare orthodontist.

Temporomandibular Joint Treatment

All treatments of temporomandibular joint disorders (TMJ) must be predetermined before treatment begins. Benefits will be denied if treatment is not predetermined.

Services covered shall include but are not limited to: TMJ examination, X-rays (including TMJ film and arthrogram), temporary repositioning splint, occlusal orthotic device (occlusal guard), removable metal overlay stabilizing appliance, fixed stabilizing appliance, occlusal equilibration, arthrocentesis and manipulation under anesthesia.

Benefits for surgical and nonsurgical treatment of TMJ are paid at 70% to a lifetime maximum of $5,000. Annual maximum of $1,000. Covered services must be: 1) appropriate for the treatment of a disorder of the temporomandibular joint; 2) effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; 3) recognized as effective, according to the professional standards of good dental practice; 4) not investigational; and 5) not primarily for cosmetic purposes. All services must be provided or ordered by the enrollee’s dentist. Any procedures that are performed in conjunction with TMJ services, and are covered benefits under another portion of the dental plan, are not covered under this portion.

Orthognathic Surgery

All orthognathic treatment must be authorized before treatment begins. Benefits will be denied if treatment is not preauthorized (predetermined).

Orthognathic treatment performed by a licensed dentist or physician is defined as the necessary surgical procedures or treatment to correct the malposition of the maxilla (upper jawbone) and/or the mandible (lower jawbone).

Benefits for orthognathic treatment are paid at 70% of the lesser of the maximum allowable fees or the fees actually charged. The lifetime maximum for orthognathic benefits is $5,000.

Complications will be covered only if treatment begins within 30 days of the original treatment.

Dental Limitations and Exclusions

Limitations

Diagnostic

- Examination is covered once in a 6-month period;
- Full mouth or panoramic X-rays limited to one set every 36 consecutive months;
- Bitewing X-rays limited to not more than one series of 4 films in any 6-month period;

Preventive

- Prophylaxis limited to one treatment in a 6-month period.
- Topical application of fluoride or fluoride varnish is covered twice in a calendar year. Preventive therapies (e.g., fluoridated varnishes) approved by DeltaCare are a covered benefit under certain conditions of oral health when performed at the suggested regimen for that therapy.
- Fissure sealants are limited to non-carious, non-restored permanent first and second molars through the age of 14. The application of fissure sealants or preventive resin restoration is a covered benefit only once in a 3-year period.
- Preventive Resin Restoration is limited to non-carious, non-restored permanent first and second molars through the age of 14. The application of preventive resin restoration or fissure sealant is a covered benefit only once in a 3-year period.
- Space maintainers are covered through age 17.

Restorative

- Restorations on the same surface(s) of the same tooth are covered once in a 2-year period;
- Crowns are covered once in a 5-year period;
- Stainless steel crowns on primary teeth are covered once in a 2-year period;
- Crowns on implants are covered as a specialty procedure once in a 5 year period, may be referred to specialist.

Periodontics

- Root planing/subgingival curettage is covered once in a 12-month period;
- Limited occlusal adjustments are covered once in a 12-month period;
- Site specific therapies (localized delivery of antimicrobial agents) approved by DeltaCare are a covered benefit under certain conditions of oral health when performed at the suggested regimen for that therapy;
- Periodontal surgery is covered once in a 3-year period;
- Soft tissue grafts are covered once in a 3-year period;
- Periodontal surgery and localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of 6 weeks and a maximum of 6 months, or the patient must have been in active supportive periodontal therapy, prior to such treatment;
- One periodontal maintenance therapy treatment, specifically periodontal prophylaxis, is covered once in a 6-month period and is to be charged at the applicable copayment level. Periodontal prophylaxis treatments over one in a 6-month period will be a benefit if in the professional judgment of the DeltaCare primary care dentist the services are necessary for the oral health of the patient. Limited to one cleaning every three months.
- Full-mouth debridement is covered once in a 3-year period;

Endodontics

- Root canal treatment on the same tooth is covered only once in a 2-year period;

Prosthodontics

- Full upper and/or lower dentures are not to exceed one each in any 5-year period and only then if it is unserviceable and cannot be made serviceable;
- Partial dentures are not to be replaced within any 5-year period from initial placement unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible:
- Denture relines are limited to one per denture during any 12 consecutive months except in the case of an immediate denture then a reline is a benefit 6 months after the initial placement;

Accidental Injury

- Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits;
- Accidental injury benefits are payable at 100% for an eligible person up to a maximum of $1,600 per patient per benefit period. Dental accidental injury benefits shall be limited to services provided to an eligible person when evaluation of treatment and development of a written treatment plan is performed within 30 days from the date of injury and shall not include any services for conditions caused by an accident occurring prior to the patient's eligibility date.
- Accidental injury. This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage;

Implant Limitations

- This benefit is limited to surgical placement of implants where the bone and soft tissues are sound and healthy.
- Additional surgery required to improve the site in order to support an implant is not covered.
- This benefit includes restoration of implants to replace single missing teeth and implants placed to support full or removable partial dentures and the full or partial denture that attaches to the implant.
- This benefit does not include an implant-supported bridge to replace multiple missing teeth.
- Implant services will only be covered if the entire implant procedure (including surgery and prosthetics) is performed while a Member or Dependent is covered under the Contract.

Orthodontic Limitations

This program provides coverage for orthodontic treatment plans provided through DeltaCare Primary Care orthodontists. The cost to the patient for the treatment plan is listed in the Schedule of Benefits and Copayments subject to the following:

1. Orthodontic treatment must be provided by a DeltaCare orthodontist.
2. Plan benefits cover active comprehensive orthodontic treatment. They include initial examination, diagnosis, consultation, initial banding, active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits.
3. Should a patient's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the patient and not DeltaCare will be responsible for payment of balance due for treatment provided after cancellation or termination. In such a case the patient's payment shall be based on the provider's allowable fee at the beginning of treatment. The amount will be pro-rated over the number of months to completion of the treatment and, will be payable by the patient on such terms and conditions as are arranged between the patient and the orthodontist.

4. If treatment is not required or the patient chooses not to start treatment after the diagnosis and consultation have been completed by the orthodontist, the patient will be charged a consultation fee of $25 in addition to diagnostic record fees.
5. Three recementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are a benefit. If any additional recementations or replacements of brackets/bands are performed, the patient is responsible for the cost at the dentist's maximum allowable fee.
6. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the patient's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the DeltaCare orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same coinsurance amount as for fixed appliances.

Orthodontic Exclusions

1. Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;
2. Retreatment of orthodontic cases;
3. Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation;
4. Surgical procedures incidental to orthodontic treatment;
5. Myofunctional therapy;
6. Surgical procedures related to cleft palate, micrognathia, or macrognathia;
7. Treatment related to temporomandibular joint disturbances;
8. Supplemental appliances not routinely utilized in typical Phase II orthodontics;
9. Restorative work caused by orthodontic treatment;
10. Phase I* orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;
11. Extractions solely for the purpose of orthodontics;
12. Treatment that began prior to the start of coverage will be prorated: Payment is based on the balance remaining after the down payment and charges prior to the date of eligibility are deducted, except for Orthodontic treatment plans transferred to DDWA from Willamette, which will be prorated based on the amount of months the patient still has remaining in treatment, and any applicable patent co-payments;
13. Charges and/or payments incurred before transfer after banding has been initiated will be prorated: Payment is based on the balance remaining after the down payment and charges prior to the date of eligibility are deducted, except for Orthodontic treatment plans transferred to DDWA from Willamette, which will be prorated based on the amount of months the patient still has remaining in treatment, and any applicable patent co-payments
14. Transfer after banding has been initiated (except for Orthodontic treatment plans transferred to DDWA from Willamette;
15. Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and would be subject to additional charges.

*Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

Orthognathic Surgery Limitations

1. Services that would be provided under medical care including but not limited to, hospital and professional services.
2. Diagnostic procedures not otherwise covered under this plan.
3. Any procedures that are performed in conjunction with orthognathic surgery and are covered benefits under another portion of this plan.

General Exclusions

- General anesthesia, intravenous and inhalation sedation, and the services of a special anesthesiologist, except that coverage will be provided for general anesthesia and intravenous sedation services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary for enrolled members through age 6, or physically or developmentally disabled;
- Cosmetic dental care. Cosmetic services include, but are not limited to, laminates, veneers or tooth bleaching;
- Services for injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, and services which are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act;
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion or erosion without sensitivity and restorations for malalignment of teeth;
- Application of desensitizing agents;
- Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation.
- Dental services performed in a hospital and related hospital fees. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:
  a. A hospital setting for the dental care must be medically necessary.
  b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.
  c. Prior to hospitalization, a request for predetermination of dental treatment performed at a hospital is submitted to and approved by DeltaCare. Such request for predetermination must be accompanied by a physician's statement of dental necessity.

  If hospital or facility care is approved, available benefits will be provided at the same percentage rate as those performed by a participating dental provider, up to the available benefit maximum.
- Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures);
- Dental expenses incurred in connection with any dental procedure started after termination of eligibility of coverage;
- Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility (except for Orthodontic treatment plans transferred to DDWA from Willamette);
- Cysts and malignancies;
- Laboratory examination of tissue specimen;
- Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide;
- Cases which in the professional judgment of the attending dentist a satisfactory result cannot be obtained or where the prognosis is poor or guarded;
- Prophylactic removal of impactions (asymptomatic, nonpathological);
- Specialist consultations for non-covered benefits;
- Orthodontic treatment which involves therapy for myofunctional problems, TMJ, dysfunctions, micrognathia, macroglossia, or hormonal imbalances causing growth and developmental abnormalities;
- All other services not specifically included on the patient's copayment schedule as a covered dental benefit;
- Treatment of fractures and dislocations to the jaw;
- Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by DeltaCare or as cited under "Emergency Care or Urgent Care".

Governing Administrative Policies

Unlike medical care where the diagnosis dictates more specifically the method of treatment to be rendered, in dental care, the dentist and patient frequently consider various treatment options.

The following guidelines are an integral part of the dental program and are consistent with the principles of accepted dental practice and the continued maintenance of good dental health.

In all cases in which the patient selects a more expensive plan of treatment that is not a covered benefit, the more expensive treatment is considered optional. The patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and the optional treatment plus any co-payment for covered benefits.

Failure to pay a scheduled co-payment at the time of service may prevent future dental services from being rendered with the exception of emergency services.

Replacement of prosthetic appliances (crowns, bridges, partials and full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement.

Partial Dentures

1. A removable cast metal partial denture is considered the covered benefit in cases where one or more posterior teeth is missing in a dental arch or a combination of one or more posterior and anterior teeth are missing in a dental arch. A three unit bridge is considered the covered benefit if only one anterior tooth is missing in a dental arch. If the patient selects another course of treatment, the patient must pay the difference in cost between the dentists' DDWA filed fees for the covered benefit and the optional treatment, plus any co-payment for the covered benefit.
2. If a cast metal partial denture will restore the case, the Primary Care Dentist will apply the difference of the cost of such procedure toward any alternative treatments which the patient and dentist may choose to use. The patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and the optional treatment plus any co-payment for the covered benefit.
3. An acrylic partial denture may be considered a covered benefit in cases involving extensive periodontal disease. Patients will pay the applicable co-payment for a cast metal partial denture.

Complete Dentures

4. If, in the construction of a denture, the patient and the Primary Care Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit (a standard denture) and optional treatment (a personalized denture or a denture that employed specialized techniques), plus any co-payment for the covered benefit.
5. Full upper and/or lower dentures are not to exceed one each in any five year period from initial placement. The patient is entitled to a new upper or lower denture only if the existing denture is more than five years old and cannot be made satisfactory by either reline or repair.

Fillings and Crowns

6. Crowns will be covered only if there is not enough retention and resistance form left in the tooth to hold a filling. For example, the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
7. In most plans a full cast predominantly metal crown (D2791) is the covered benefit on molar teeth. In these plans all other crowns (high noble, noble, porcelain, porcelain fused to metal) on molar teeth are considered optional treatment. When optional treatment is performed, the patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and the DDWA filed fee for the optional treatment (not to exceed $200.00), plus any co-payment for the covered benefit. In some plans all crown types are a covered benefit on molar teeth and there is no optional treatment. Always consult the patients benefit plan. The patient must be permitted the option of the cast metal crown as a benefit if desired.
8. The DeltaCare program provides amalgam (posterior) and resin-based (anterior) restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional, and if provided, the patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and optional treatment, plus any co-payment for the covered benefit.

9. A restoration is a covered benefit only when required for restorative reasons (radiographic evidence of decay or missing tooth structure). Restorations placed for any other purposes including, but not limited to cosmetics, abrasion, erosion, restoring or altering vertical dimension, or the anticipation of future fractures, are not covered benefits.
10. Composite resin restorations in posterior teeth are a covered benefit once in a two-year period.
11. Anterior porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. An allowance will be made for an acrylic crown. If performed, the patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and optional treatment, plus any co-payment for the covered benefit.
12. A crown placed on a specific tooth is allowable only once in a five year period from initial placement.
13. A crown used as an abutment to a partial denture for purposes of re-contouring, repositioning or to provide additional retention is not covered unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a partial denture is required.

Fixed Bridges

14. A fixed bridge to replace ONE missing permanent anterior tooth is covered for patients 16 or older. Such treatment will be covered if the patient's oral health and general condition permits.
15. Fixed bridges for patients under the age of 16 are optional to a partial denture.
16. A fixed bridge to replace more than one permanent anterior tooth or any number of permanent posterior teeth is optional to a removable partial denture. The patient must pay the difference in cost between the dentist's filed fee for the covered benefit (a removable partial denture) and the optional treatment (a fixed bridge), plus any co-payment for the covered benefit.
17. Fixed bridges are not a benefit when provided in connection with a partial denture on the same arch. A fixed bridge is not a covered benefit once a removable partial denture has been delivered in the same arch.
18. Replacement of an existing fixed bridge (to replace ONE missing permanent anterior tooth) is covered after five years from initial placement and only if it involves the same teeth as the prior bridge.

Reconstruction

19. The DeltaCare program provides coverage for procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ) are not covered benefits, unless the treatment is specifically to manage a TMJ disorder and the group has TMJ benefits specifically included above.

    Extensive treatment plans involving 10 or more crowns or units of fixed bridgework is considered full mouth reconstruction.. Predetermination must include full treatment plan, full mouth x rays and narratives on requested treatment. Build ups will be included in the full mouth treatment plans. Maximum payable, if approved, is $3,000 annually up to $9,000 over 3 consecutive years.

Specialized Techniques

20. Noble or titanium metal for removable appliances, crowns, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization, are all considered optional treatment. If performed, the patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and optional treatment, plus any co-payment for the covered benefit. (As long as the patient has the option of the covered benefit procedure.)

Preventive Control Programs

21. Soft tissue management programs are not covered. Periodontal pocket charting, root planing/scaling/curettage, oral hygiene instruction and prophylaxis are covered benefits and, if performed as part of a soft tissue management program, will be provided for listed co-payments, if any. Irrigation, infusion, special tooth brush, etc., are considered non-covered services. If these services are performed, the patient is responsible for the cost.
22. Follow-up examinations for reevaluation, particularly periodontal reevaluation, are considered to be part of the general services rendered.

Interim partials (Stayplates)

23. Interim partials (Stayplates) in conjunction with fixed or removable appliances are only a benefit to replace recently extracted anterior permanent teeth during a healing period.

Frenectomy

24. The frenum can be excised when the tongue has limited mobility; or there is a large diastema between anterior teeth; or when the frenum interferes with a prosthetic appliance.

Pedodontia

1. Pedodontic referrals for dependent children through age three are covered at 100% of the agreed upon fee less any applicable co-payments for covered benefits and children four years and older are at 50% of agreed upon fee less any applicable co-payments for covered services.

Treatment Planning

2. The objective of this program is to see that all patients are brought to a good level of oral health and that this level of oral health is maintained. To achieve these objectives takes treatment planning. Priorities have been established on the following basis:
   a. Pain and dysfunction
   b. Active dental disease – active decay and periodontal disease
   c. Replacement of missing teeth

d. Exceptions are made to this treatment planning concept based on individual circumstances.

Eligibility

In these sections we may also refer to employees, retirees and surviving dependents as “subscribers” or “enrollees.”

The employee’s employing agency will inform the employee whether he or she is eligible for insurance coverage upon employment and whenever the employee’s eligibility status changes. The communication will include information about the employee’s right to appeal eligibility and enrollment decisions. Information about an employee’s right to an appeal can be found on page 31 of this booklet.

The Public Employee’s Benefits Board (PEBB) Program will determine if an employee is eligible to enroll in retiree insurance coverage when the PEBB Program receives a completed Retiree Coverage Enrollment/Change form. If the employee does not have substantive eligibility or meet the procedural requirements for enrollment in retiree insurance, the PEBB Program will notify the employee of his or her right to an appeal. Information about an employee’s right to an appeal can be found on page 32 of this certificate of coverage.

The PEBB Program will determine if a dependent is eligible to continue enrollment in insurance coverage as a surviving dependent when the PEBB Program receives a completed Retiree Coverage Enrollment/Change form. If the PEBB Program determines the dependent does not have substantive eligibility or does not meet the procedural requirements for enrollment in retiree insurance, the PEBB Program will notify the dependent of his or her right to an appeal. Information about a dependent’s right to an appeal can be found on page 32 of this booklet.

Retirees, surviving dependents, and their enrolled dependents, are required to enroll in Medicare Part A and Part B if entitled.

Enrollees who are entitled to Medicare must enroll and maintain their enrollment in Medicare Part A and Part B. This is a condition of their enrollment. Enrollees must provide a copy of their Medicare card to the PEBB Program as proof of Medicare enrollment. If an enrollee is not entitled to either Medicare Part A or Part B on his or her 65th birthday, the enrollee must provide the PEBB Program with a copy of the appropriate documentation from the Social Security Administration. The only exception to this rule is for employees who retired before July 1, 1991.

Eligible Dependents

To enroll in a dental plan, a dependent must be eligible and the subscriber must follow the procedural requirements described in the Enrollment section of this booklet.

The PEBB Program or employing agency verifies the eligibility of all dependents and requires documents from subscribers that prove a dependent's eligibility. The following are eligible as dependents:

1. Lawful spouse.

2. Registered domestic partner, defined to include the following:

(a) Effective January 1, 2010, a state-registered domestic partner; or

(b) A domestic partner who was qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and was continuously enrolled under the subscriber.

3. Children.

Children are eligible up to age 26 except as described in subsection (i) of this section. Children are defined as the subscriber's:

(a) Children as defined in state statutes that establish the parent-child relationship;

(b) Biological children, where parental rights have not been terminated;

(c) Stepchildren. The stepchild's relationship to a subscriber (and eligibility as a PEBB dependent) ends on the same date the subscriber's legal relationship with the spouse or registered domestic partner ends through divorce, annulment, dissolution, termination, or death;

(d) Legally adopted children;

(e) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(f) Children of the subscriber's registered domestic partner;

(g) Children specified in a court order or divorce decree;

(h) Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. "Children" does not include foster children for whom support payments are made to the subscriber through the state Department of Social and Health Services foster care program; and

(i) Children of any age with a developmental disability or physical handicap that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before age 26.

- The subscriber must provide evidence of the disability and evidence that the condition occurred before age 26;
- The subscriber must notify the PEBB Program in writing when his or her dependent is not eligible under this section. The notification must be received by the PEBB Program no later than 60 days after the date that a child age 26 or older no longer qualifies under this subsection;
- A child with a developmental disability or physical handicap who becomes self-supporting is not eligible under this subsection as of the last day of the month in which he or she becomes capable of self-support;
- A child with a developmental disability or physical handicap age 26 and older who becomes capable of self-support does not regain eligibility under (i) of this subsection if he or she later becomes incapable of self-support;
- The PEBB Program will periodically certify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday.

.4. Parents.

a. Parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as all of the following are met:
   - The parent maintains continuous enrollment in a PEBB medical plan;
   - The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
   - The subscriber continues enrollment in PEBB insurance coverage; and
   - The parent is not covered by any other group medical plan.

b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not enroll additional dependents to their insurance coverage.

Enrollment

A PEBB Program subscriber or subscriber's dependent is eligible to enroll in only one PEBB dental plan even if eligibility criteria are met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two or more parents working for employers that participate in PEBB coverage may be enrolled as a dependent under one parent, but not more than one.

Employees are <u>required</u> to enroll in a dental plan under their employing agency. Employees must submit an *Employee Enrollment/Change* form to their employing agency no later than 31 days after the date the employee becomes eligible. To enroll an eligible dependent, the employee must include the dependent's information on the form and provide the required document(s) as evidence of the dependent's eligibility. A dependent must be enrolled in the same health plan coverage as the subscriber If the employee does not meet the 31-day requirement, the employee will be enrolled in the Uniform Dental Plan and any eligible dependents cannot be enrolled until the next open enrollment.

Retirees and surviving dependents <u>may</u> enroll in dental. If a retiree or surviving dependent chooses to enroll in a dental plan at retirement or during an open enrollment, any dependents enrolled on the subscriber's account will be enrolled in dental as well. The retiree or surviving dependent must stay enrolled in retiree dental coverage for at least two years before dental can be canceled.

Retiring employees and surviving dependents (except for survivors of emergency service personnel killed in the line of duty) must submit a Retiree Coverage Election Form to the PEBB Program no later than 60 days after the date they become eligible to enroll. If a retiring employee or a surviving dependent wants to enroll an eligible dependent(s), the subscriber must include the dependent's information on the Retiree Coverage Election Form and provide any required document(s) as evidence of the dependent's eligibility

A subscriber or a subscriber's dependents may be enrolled during the annual open enrollment (see Annual Open Enrollment section below) or during a special open enrollment (see Special Open Enrollment section below. The subscriber must provide evidence of the event that created the special open enrollment.

Subscribers are required to remove dependents no later than 60 days from the date a dependent no longer meets the eligibility criteria described under "Eligible dependents" on page 21 of this booklet. Consequences for not submitting notice within 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue dental plan coverage under one of the continuation coverage options described on page 27 of this booklet;
- The subscriber may be billed for services that were rendered after the dependent lost eligibility;
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber may be responsible for premiums paid by the state for the Dependent's dental plan coverage after the dependent lost eligibility.

When Dental Coverage Begins

For an employee and the employee's eligible dependent, enrolled when the employee is newly eligible, dental plan enrollment will begin the first day of the month following the day the employee became eligible. If the employee becomes eligible on the first working day of the month, the coverage will begin on that date.

For an eligible employee and his or her dependents enrolling in PEBB retiree insurance coverage within 60 days of the employee's employer-paid or COBRA coverage ending, dental coverage begins on the first day of the month following the loss of other coverage. For a retiree who deferred enrollment and is enrolling in PEBB retiree insurance no later than 60 days following a loss of other coverage, dental coverage will begin the first day of the month following the loss of other coverage.

For an eligible surviving dependent, dental coverage will continue without a gap, with payment of premiums.

For an enrollee enrolled during the annual open enrollment, dental coverage will begin on January 1 of the upcoming year.

For an enrollee enrolled during a special open enrollment, dental coverage will begin the first of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day.

Exceptions:

1. If the special enrollment is due to birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, dental coverage will begin the month in which the event occurs.
2. If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, or a child who becomes eligible as a dependent with a disability, dental coverage will begin on the first day of the month following eligibility certification.

Annual Open Enrollment

Employees may make a change to their enrollment during the annual open enrollment as follows:

- Enroll or remove eligible dependents; or
- Change dental plan choice.

All other subscribers may make a change to their enrollment as follows:

- Enroll in or drop enrollment in a dental plan;
- Enroll or remove eligible dependents; or
- Change dental plan choice.

If subscribers make changes during annual open enrollment, the required forms must be submitted no later than the last day of the annual open enrollment.

Special Open Enrollment

A subscriber may make an enrollment change outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under Internal Revenue Code (IRC) and correspond to, and be consistent with, the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both.

To make an enrollment change, the subscriber must submit the required appropriate form(s) no later than 60 days after the event that creates the special open enrollment, with the following exceptions:

1. If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB Program by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the subscriber **must** submit the required enrollment form no later than 12 months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.
2. A retiree or surviving dependent may cancel a dependent's enrollment at any time by providing written notice to the PEBB Program. The dependent will be removed from the subscriber's coverage prospectively.

Employees must submit the required change form to their employing agency. All other subscribers must submit the required change form to the PEBB Program. In addition to the required forms, the PEBB Program or employing agency will require the subscriber to prove a dependent's eligibility or provide evidence of the event that created the special open enrollment.

What events trigger a Special Open Enrollment for the Subscriber to Change His or Her Dental Plan?

Any one of the following events may create a special open enrollment:

1. Subscriber acquires a new dependent due to:
    a. Marriage or registering a domestic partnership ,

b. Birth, adoption or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption,
c. A child becoming eligible as an extended dependent through legal custody or legal guardianship, or
d. A child becoming eligible as a dependent with a disability.

2. Subscriber, or a subscriber's dependent, loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber or a subscriber's dependent has a change in employment status that affects the subscriber's or dependent's eligibility for the employer contribution toward group health coverage;
4. Subscriber, or a subscriber's dependent has a change in residence that affects dental plan availability. If the subscriber moves and the subscriber's current dental plan is not available in the new location the subscriber must select a new dental plan.
5. A court order or National Medical Support Notice requires the subscriber, or any other individual to provide insurance coverage for an eligible dependent (a former spouse or former registered domestic partner is not an eligible dependent);
6. Subscriber or a subscriber's dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicaid or a CHIP
7. Subscriber or a subscriber's dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.
8. Subscriber or a subscriber's dependent becomes entitled to coverage under Medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicare, or enrolls in or disenrolls from a Medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or a subscriber's dependent's entitlement to Medicare, the subscriber must select a new health plan ;
9. Subscriber or a subscriber's dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a Health Savings Account (HSA). The PEBB Program may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA.
10. Subscriber or subscriber's dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or the subscriber's dependent for a specific condition or ongoing course of treatment. The subscriber may not change his or her health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but not limit its consideration to the following:
    a. Active cancer treatment such as chemotherapy or radiation therapy for up to 90 days or until medically stable; or
    b. Transplant within the last 12 months; or
    c. Scheduled surgery within the next 60 days (elective procedures within the next 60 days do not qualify for continuity of care); or
    d. Recent major surgery still within the postoperative period of up to eight weeks or
    e. Third trimester of pregnancy;

NOTE: If an enrollee's provider or dental care facility discontinues participation with the dental plan, the enrollee may not change dental plans until the next open enrollment period, unless the PEBB Program determines that a continuity of care issue exists. The [insert dental plan name] dental plan nor Delta Dental of Washington cannot guarantee that any one dentist, facility, or other provider will be available or remain under contract with us.

What Events Trigger a Special Open Enrollment for the Subscriber to Enroll or Remove Eligible Dependents?

Any one of the following events may create a special open enrollment:

1. Subscriber acquires a new dependent due to:
    a. Marriage or registering a domestic partnership ,
    b. Birth, adoption or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption,
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship, or
    d. A child becoming eligible as a dependent with a disability.

2. Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber or a subscriber's dependent has a change in employment status that affects the subscriber's or subscriber's dependent's eligibility for the employer contribution toward group health coverage;
4. Subscriber or a subscriber's dependent has a change in enrollment under another employer plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment;
5. Subscriber's dependent has a change in residence from outside of the United States to within the United States;
6. A court order or national medical support notice requires the subscriber, or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former or registered domestic partner is not an eligible dependent);
7. Subscriber or a subscriber's dependent becomes entitled to coverage under Medicaid or a CHIP program, or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicaid or CHIP
8. Subscriber or a subscriber's dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.

When Dental Coverage Ends

Coverage ends on the following dates:

1. At midnight on the last day of the month when any individual ceases to be eligible.
2. On the date a plan terminates, if that should occur. The individual will have the opportunity to enroll in another PEBB plan.
3. For an enrollee who chooses not to continue enrollment, or is ineligible to continue enrollment under one of the options described in the "Options for Continuing PEBB Dental Coverage" on Page 29 of this booklet, coverage ends at midnight on the last day of the month in which he or she ceases to be eligible.
4. If the subscriber stops paying monthly premiums, coverage ends for the subscriber and enrolled dependents on the last day of the month for which the last full premium was paid. A full month's premium is charged for each calendar month of coverage. Premium payments are not prorated if an enrollee dies or requests to cancel his or her coverage before the end of the month.

The subscriber is responsible for timely payment of premiums and reporting changes in eligibility or address.

Failure to report changes can result in loss of premiums and loss of the subscriber and his or her dependents' right to continue coverage under the federal COBRA law or one of the other options described in the "Options for Continuing PEBB Dental Coverage," on Page 29. If you need help getting the proper form for communicating changes to the PEBB Program, call PEBB Customer Service at 1-800-200-1004.

National Medical Support Notice (NMSN) or Court Order

When a National Medical Support Notice (NMSN) or court order requires a subscriber to provide health plan coverage for a dependent child the following provisions apply:

(1) The subscriber may enroll his or her dependent child and request changes to his or her health plan coverage as described under subsection (3) of this section. Employees submit the required forms to their employing agency. All other subscribers submit the required forms to the PEBB Program.

(2) If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN or court order, the employing agency or the PEBB Program may make enrollment or health plan coverage changes according to subsection (3) of this section upon request of:

(a) The child's other parent; or

(b) Child support enforcement program.

(3) Changes to health plan coverage or enrollment are allowed as directed by the NMSN or court order:

(a) The dependent will be enrolled under the subscriber's health plan coverage as directed by the NMSN or court order;

(b) An employee who has waived medical will be enrolled in medical coverage as directed by the NMSN or court order, in order to enroll the dependent;

(c) The subscriber's selected health plan will be changed if directed by the NMSN or court order;

(d) If the dependent is already enrolled under another PEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN or court order.

(4) Health plan enrollment will begin the first day of the month following receipt of the NMSN or court order. If the NMSN or court order requires a change from the subscriber's selected health plan, the change will begin the first day of the month following receipt of the NMSN or court order.

Options for Continuing PEBB Dental Coverage

Subscribers and their dependents covered by this dental plan may be eligible to continue enrollment during temporary or permanent loss of eligibility. There are four possible continuation coverage options for PEBB enrollees:

1. COBRA
2. PEBB Extension of Coverage
3. Leave Without Pay (LWOP) Coverage
4. PEBB retiree insurance coverage

The first three options temporarily extend group insurance coverage if certain circumstances occur that would otherwise end an enrollee’s dental plan coverage. COBRA coverage is governed by eligibility and administrative requirements in federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative that may be appropriate in specific situations.

PEBB retiree insurance coverage above is only available to retiring employees and surviving dependents who meet eligibility and procedural requirements.

Dependents of an eligible employee or retiree are eligible to enroll as a survivor under PEBB retiree insurance coverage. An eligible survivor must submit the required forms to enroll or defer enrollment in a PEBB medical plan no later than 60 days after the date of the employee's or retiree's death.

Continuation of coverage is administered by the PEBB Program. Refer to the *PEBB Continuation of Coverage Election Notice* booklet for specific details or call PEBB Program Customer Service at 1-800-200-1004.

Family and Medical Leave Act of 1993

Employees on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward insurance coverage in accordance with the federal FMLA. The employee's employing agency is responsible for determining if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay the employee premium contribution during this period to maintain eligibility. If the employee's contribution toward premiums is more than 60 days delinquent, insurance coverage will end as of the last day of the month for which a full premium was paid

If an employee exhausts the period of leave approved under FMLA, insurance coverage may be continued by self-paying the full premium set by the HCA, with no contribution from the employer while on approved leave. For additional information on continuation of coverage; see the section titled "Options for Continuing PEBB Health Plan Coverage."

Payment of Premium During a Labor Dispute

Any employee or dependent whose monthly premiums are paid in full or in part by the employer may pay premiums directly to this dental plan or the HCA if the employee's compensation is suspended or canceled directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the employee's compensation is suspended or canceled, the employee shall be notified immediately by the HCA, in writing, by mail sent to the last address of record with the HCA, that the employee may pay premiums as they become due as provided in this section.

Appeals of dental plan administration

Any enrollee aggrieved by a decision regarding the administration of a PEBB dental plan, may appeal that decision by following the appeal provisions of the plan, with the exception of eligibility, enrollment, and premium payment determinations.

Termination for Just Cause

The purpose of this provision is to allow for a fair and consistent method to process the plan designated provider's request to terminate coverage from this plan for Just Cause.

An enrollee may have coverage terminated by HCA if the enrollee:

1. Fails to comply with the PEBB Program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB Program;
2. Knowingly provides false information;
3. Commits abuse or intentional misconduct. Examples of abuse or intentional misconduct may include, but are not limited to, abusive or threatening conduct repeatedly directed to an HCA employee, a health plan, plan designated provider or other HCA contracted vendor providing insurance coverage on behalf of the HCA, its employees, or other persons; or
4. Repeatedly fails to make timely copayments.

The PEBB Program will enroll the employee or dependent in another dental plan upon termination from this plan. The employee has a right to appeal the decision through the eligibility appeal process described on page 32 of this Certificate of Coverage.

General Provisions

Appealing a Determination of Ineligibility for Insurance Coverage

Any employee of a state agency or his or her dependent may appeal a decision made by the employing state agency about public employee benefits eligibility or enrollment to the employing state agency.

Any employee of an employer group or his or her dependent who is aggrieved by a decision made by an employer group with regard to PEBB eligibility or enrollment may appeal that decision to the employer group.

Any enrollee may appeal a decision made by the PEBB Program about eligibility, enrollment, or premium payments to the PEBB appeals committee.

Any enrollee may appeal a decision about the administration of a PEBB dental plan by following the appeal provisions of the plan, with the exception of eligibility, enrollment, and premium payment determinations.

Relationship to Law and Regulations

Any provision of this Certificate of Coverage that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

Release of Information

Enrollees may be required to provide the Uniform Dental Plan or the HCA with information necessary to determine eligibility, administer benefits or process claims. This could include, but is not limited to, dental records. Coverage could be denied if enrollees fail to provide such information when requested.

When a Third Party is Responsible for Injury or Illness (Subrogation)

To the extent of any amounts paid by DeltaCare for an eligible person on account of services made necessary by an injury to or condition of his or her person, DeltaCare shall be subrogated to his or her rights against any third party liable for the injury or condition. DeltaCare shall, however, not be obligated to pay for such services unless and until the eligible person, or someone legally qualified and authorized to act for him or her, agrees to:

- Include those amounts in any insurance claim or in any liability claim made against the third party for the injury or condition;
- Repay DDWA those amounts included in the claim from the excess received by the injured party, after full compensation for the loss is received;
- Cooperate fully with DeltaCare in asserting its rights under the Contract, to supply DeltaCare with any and all information and execute any and all instruments DeltaCare reasonably needs for that purpose.

Provided the injured party is in compliance with the above, DeltaCare will prorate any attorneys' fees incurred in the recovery. What this means to you is that if you receive this program's benefits for an injury or condition possibly caused by another person, you must include in your insurance claim or liability claim the amount of those benefits. After you have been fully compensated for your loss, any money recovered in excess of full compensation must be used to reimburse DDWA. DDWA will prorate any attorneys' fees against the amount owed.

Uninsured or Underinsured Motorist Coverage

This DeltaCare program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy or other similar type of coverage.

Claim Review and Appeal

Predetermination of Benefits

Covered dental benefits that which are prepaid to your Primary Care Provider are documented in the DeltaCare provider manual and the member's benefit booklet. These procedures do not require predetermination and are considered covered. If the treatment will be provided by a provider other than the assigned PCP, DDWA recommends, and will accept a request for a predetermination of benefits.

A predetermination is a request made by your PCP to DDWA to determine your benefits for a particular service. This predetermination will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services.

A predetermination is not an authorization for services but a notification of Covered Dental Benefits available at the time the predetermination is made and is not a guarantee of payment (please refer to the “Initial Benefits Determination” section regarding claims requirements).

A standard predetermination is processed within 15 days from the date of receipt of all appropriate information. If the information received is incomplete DDWA will notify you and your Dentist in writing that additional information is required in order to process the predetermination. Once the additional information is available your Dentist should submit a new request for a predetermination to DDWA.

In the event your benefits are changed, terminated, or you are no longer covered under this Plan, the predetermination is no longer valid. DDWA will make payments based on your coverage at the time treatment is provided.

Urgent Predetermination Requests

Should a predetermination request be of an urgent nature, whereby a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or dentist who has knowledge of the medical condition, DDWA will review the request within 72-hours from receipt of the request and all supporting documentation. When practical, DDWA may provide notice of determination orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is allowed without a requirement to obtain a predetermination in an emergency situation subject to the contract provisions.

Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission to DDWA for payment, modification or denial of services. In accordance with regulatory requirements, DDWA processes all clean claims within 30 days from the date of receipt. Clean claims are claims that have no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. Claims not meeting this definition are paid or denied within 60 days of receipt.

If a claim is denied, in whole or in part, or is modified, you will be furnished with a written explanation of benefits (EOB) that will include the following information:

- The specific reason for the denial or modification
- Reference to the specific plan provision on which the determination was based
- Your appeal rights should you wish to dispute the original determination

Appeals of Denied Claims

How to contact us

DDWA will accept notice of an Urgent Care Request or Appeal if made by you, your covered dependent, or an authorized representative orally by contacting us at the telephone number below or in writing directed to Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983. You may include any written comments, documents or other information that you believe supports your claim. For more information please call 1-800-650-1583.

Authorized Representative

You may authorize another person to represent you or your child and receive communications from DDWA regarding your specific appeal. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed Authorized Representative form. The appeal process will not commence until this form is received. Should the form, or any other document confirming the right of the individual to act on your behalf, i.e., power of attorney, not be returned, the appeal will be closed.

Informal Review

If your claim for dental benefits has been completely or partially denied, you have the right to request an informal review of the decision. Either you, or your authorized representative (see above), must submit your request for a review within 180 days from the date your claim was denied (please see your Explanation of Benefits form). A request for a review may be made orally or in writing and include the following information:

- Your name and ID number
- The claim number (from your Explanation of Benefits form)
- The name of the dentist

DDWA will review your claim, make a determination within 14 days of receiving your request, and may take up to an additional 16 days with the delivery of this notice, for a total of 30 days. DDWA will send you a written notification of the review decision and information regarding any further appeal rights available should the result be unfavorable to you. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision. Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination.

Formal Review

If you are dissatisfied with the outcome of the informal review, you may request in writing that your claim be reviewed formally by the DDWA Appeals Committee. This Committee includes only persons who were not involved in either the original claim decision or the informal review.

Your request for a review by the Appeals Committee must be made within 90 days of the post-marked date of the letter notifying you of the informal review decision. Your request should include the information noted above plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeals Committee will review your claim and make a determination within 30 days of receiving your request, and send you a written notification of the review decision. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision.

Whenever DDWA makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review consistent with applicable regulation.

When the Enrollee Has Other Dental Coverage

Coordination of This Contract's Benefits with Other Benefits: The coordination of benefits (COB) provision applies when you have dental coverage under more than one *Plan*. *Plan* is defined below.

Note: This Plan will always be considered primary (the plan whose benefits are determined first), except under the following circumstances: 1) orthodontic benefits that are payable on a fee-for-service basis shall be based on the rules below; and 2) if both this Contract and the other Plan have provisions stating they are primary, then see the "*Order of Benefit Determination Rules*" below to establish the order of benefit payment under the Plans.

The order of benefit determination rules govern the order in which each *Plan* will pay a claim for benefits. The *Plan* that pays first is called the *Primary Plan*. The *Primary Plan* must pay benefits according to its policy terms without regard to the possibility that another *Plan* may cover some expenses. The *Plan* that pays after the *Primary Plan* is the *Secondary Plan*. The *Secondary Plan* may reduce the benefits it pays so that payments from all *Plan*s do not exceed 100 percent of the total *Allowable Expense*.

Definitions: For the purpose of this section, the following definitions shall apply:

A "***Plan***" is any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *Plan* and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate *Plan*.

- *Plan* includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), *Closed Panel Plan*s or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental *Plan*, as permitted by law.
- *Plan* does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident and similar coverage that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; A state *plan* under Medicaid; A governmental *plan*, which, by law, provides benefits that are in excess of those of any private insurance *plan* or other nongovernmental *plan*; automobile insurance policies required by statute to provide medical benefits; benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined by law or coverage under other federal governmental *Plan*s, unless permitted by law.

Each contract for coverage under the above bullet points is a separate *Plan*. If a *Plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *Plan*.

"***This Plan***" means, in a COB provision, the part of the contract providing the dental benefits to which the COB provision applies and which may be reduced because of the benefits of other *Plan*s. Any other part of the contract providing dental benefits is separate from *This Plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether *This Plan* is a *Primary Plan* or *Secondary Plan* when you have dental coverage under more than one *Plan*.

When *This Plan* is primary, it determines payment for its benefits first before those of any other *Plan* without considering any other *Plan*'s benefits. When *This Plan* is secondary, it determines its benefits after those of another *Plan* and must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plan*s for the claim are coordinated up to 100 percent of the total *Allowable Expense* for that claim. This means that when *This Plan* is secondary, it must pay the amount which, when combined with what the *Primary Plan* paid, does not exceed 100 percent of the *Allowable Expense*. In addition, if *This Plan* is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the *Primary Plan*) and record these savings as a benefit reserve for you. This reserve must be used to pay any expenses during that calendar year, whether or not they are an *Allowable Expense* under *This Plan*. If *This Plan* is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

"***Allowable Expense ,***"except as outlined below, means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the *Plans* covering you. When coordinating benefits as the secondary plan, Delta Dental of Washington must pay an amount which, together with the payment made by the *Primary Plan*, cannot be less than the same allowable expense as the secondary plan would have paid if it was the primary plan. In no event will Delta Dental of Washington be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A and Part B or Part C is primary, Medicare's allowable amount is the highest expense. An expense or a portion of an expense that is not covered by any of the *plan*s is not an allowable expense. The following are examples of expenses that are not *Allowable Expense*s:

- If you are covered by two or more *Plan*s that compute their benefit payments on the basis of a maximum allowable amount, relative value schedule reimbursement method or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specific benefit is not an *Allowable Expense*.
- If you are covered by two or more *Plan*s that provide benefits or services on the basis of negotiated fees, an amount in excess of this plan's negotiated fees is not an *Allowable Expense*.

"***Closed Panel Plan***" is a *Plan* that provides dental benefits to you in the form of services through a panel of providers who are primarily employed by the *Plan*, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

"***Custodial Parent***" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules: When you are covered by two or more *Plan*s, the rules for determining the order of benefit payments are as follows:

The *Primary Plan* must pay or provide its benefits as if the *Secondary Plan* or *Plans* did not exist.

A *Plan* that does not contain a coordination of benefits provision that is consistent with Chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both *Plan*s state that the complying *Plan* is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the *Plan* provided by the contract holder.

A *Plan* may consider the benefits paid or provided by another *Plan* in calculating payment of its benefits only when it is secondary to that other *Plan*.

Each *Plan* determines its order of benefits using the first of the following rules that apply:

"***Non-Dependent or Dependent***:" The *Plan* that covers you other than as a *Dependent*, for example as an employee, member, policyholder, subscriber or retiree is the *Primary Plan* and the *Plan* that covers you as a *Dependent* is the *Secondary Plan*. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *Plan* covering you as a *Dependent*, and primary to the *Plan* covering you as other than a *Dependent* (e.g., a retired employee), then the order of benefits between the two *Plan*s is reversed so that the *Plan* covering you as an employee, member, policyholder, subscriber or retiree is the *Secondary Plan* and the other *Plan* is the *Primary Plan*.

"***Dependent Child Covered Under More Than One Plan:***" Unless there is a court decree stating otherwise, when a *Dependent* child is covered by more than one *Plan* the order of benefits is determined as follows:

1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
    a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
    b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.
2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    a) If a court decree states that one of the parents is responsible for the Dependent child's dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;
    b) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;
    c) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits;
    d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the Dependent child, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or
    e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:
        I. The *Plan* covering the *Custodial Parent*, first;
        II. The *Plan* covering the spouse of the *Custodial Parent*, second;
        III. The *Plan* covering the non*custodial Parent*, third; and then
        IV. The *Plan* covering the spouse of the non*custodial Parent*, last
3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

"***Active Employee or Retired or Laid-off Employee:***" The *Plan* that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the *Primary Plan*. The *Plan* covering you as a retired or laid-off employee is the *Secondary Plan*. The same would hold true if you are a *Dependent* of an active employee and you are a *Dependent* of a retired or laid-off employee. If the other *Plan* does not have this rule, and as a result, the *Plan*s do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

"***COBRA or State Continuation Coverage:***" If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another *Plan*, the *Plan* covering you as an employee, member, subscriber or retiree or covering you as a *Dependent* of an employee, member, subscriber or retiree is the *Primary Plan* and the COBRA or state or other federal continuation coverage is the *Secondary Plan*. If the other *Plan* does not have this rule, and as a result, the *Plan*s do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

"***Longer or Shorter Length of Coverage:***" The *Plan* that covered you as an employee, member, policyholder, subscriber or retiree longer is the *Primary Plan* and the *Plan* that covered you the shorter period of time is the *Secondary Plan*.

If the preceding rules do not determine the order of benefits, the *Allowable Expense*s must be shared equally between the *Plan*s meeting the definition of *Plan*. In addition, *This Plan* will not pay more than it would have paid had it been the *Primary Plan*.

Effect on the Benefits of *This Plan*: When *This Plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *Plan*s during a claim determination period are not more than the *Total Allowable Expenses*. In determining the amount to be paid for any claim, the *Secondary Plan* must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plan*s for the claim do not exceed 100 percent of the total *Allowable Expense* for that claim. Total *Allowable Expense* is the *Allowable Expense* of the *Primary Plan* or the *Secondary Plan up to this plan's allowable expense*. In addition, the *Secondary Plan* must credit to its *Plan* deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

How We Pay Claims When We Are Secondary: When we are knowingly the *Secondary Plan*, we will make payment promptly after receiving payment information from your *Primary Plan*. Your *Primary Plan*, and we as your *Secondary Plan*, may ask you and/or your provider for information in order to make payment. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the *Primary Plan* fails to pay within 60 calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim for us to make payment as if we were your *Primary Plan*. In such situations, we are required to pay claims within 30 calendar days of receiving your claim and the notice that your *Primary Plan* has not paid. This provision does not apply if Medicare is the *Primary Plan*. We may recover from the *Primary Plan* any excess amount paid under the "right of recovery" provision in the *plan*.

- If there is a difference between the amounts the *plan*s allow, we will base our payment on the higher amount. However, if the *Primary Plan* has a contract with the provider, our combined payments will not be more than the amount called for in our contract . Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other *plan*s.

- We will determine our payment by subtracting the amount paid by the *Primary Plan* from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *plan*s for the claim does not exceed one hundred percent of the total allowable expense (the highest of the amounts allowed under each *plan* involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the *plan*(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid.

Right to Receive and Release Needed Information: Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under *This Plan* and other *Plan*s. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under *This Plan* and other *Plan*s covering you. The Company need not tell, or get the consent of, any person to do this. To claim benefits under *This Plan* you must give the Company any facts it needs to apply those rules and determine benefits payable.

Facility of Payment: If payments that should have been made under *This Plan* are made by another *Plan*, the Company has the right, at its discretion, to remit to the other *Plan* the amount the Company determines appropriate to satisfy the intent of this provision. The amounts paid to the other *Plan* are considered benefits paid under *This Plan*. To the extent of such payments, the Company is fully discharged from liability under *This Plan*.

Right of Recovery: The Company has the right to recover excess payment whenever it has paid *Allowable Expense*s in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The Company may recover excess payment from any person to whom or for whom payment was made or any other Company or *Plan*s.

If payments that should have been made under *This Plan* are made by another *Plan*, DDWA has the right, at its discretion, to remit to the other *Plan* the amount it determines appropriate. To the extent of such payments, DDWA is fully discharged from liability under *This Plan*.

Notice to covered persons If you are covered by more than one health benefit *Plan*, and you do not know which is your *Primary Plan*, you or your provider should contact any one of the health *Plan*s to verify which *Plan* is primary. The health *Plan* you contact is responsible for working with the other health *Plan* to determine which is primary and will let you know within 30 calendar days.

CAUTION: All health *Plan*s have timely claim filing requirements. If you, or your provider, fail to submit your claim to a secondary health *Plan* within the *Plan*'s claim filing time limit, the *Plan* can deny the claim. If you experience delays in the processing of your claim by the primary health *Plan*, you or your provider will need to submit your claim to the secondary health *Plan* within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one *Plan* you should promptly report to your providers and *Plan*s any changes in your coverage.

Subscriber Rights and Responsibilities

At Delta Dental of Washington our mission is to provide quality dental benefit coverage to employers and employees throughout Washington. We view our benefit packages as a partnership between Delta Dental of Washington, our subscribers and our participating member dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

The enrollee or dependent has the right to:

- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.

- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to specialists when services are required to complete a treatment, diagnosis or when your primary care dentist makes a specific referral for specialty care.
- Contact Delta Dental of Washington customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our Web site at DeltaDentalWA.com
- Appeal orally or in writing, decisions or grievances regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

To receive the best oral health care possible, it is the enrollee or dependents responsibility to:

- Know your benefit coverage and how it works.
- Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24 hours' notice for appointment cancellations before they will waive service charges.
- Ask questions about treatment options that are available to you regardless of coverage levels or cost.
- Give accurate and complete information about your health status and history and the health status and history of your family to all care providers when necessary.
- Read carefully and ask questions about all forms and documents that you are requested to sign, and request further information about items you do not understand.
- Follow instructions given by your dentist or his or her staff concerning daily oral health improvement or post-service care.
- Send requested documentation to Delta Dental of Washington to assist with the processing of claims.
- If applicable, pay the dental office the appropriate copayments amount at time of visit.
- Respect the rights, office policies and property of each dental office you have the opportunity to visit.
- Inform your dentist and your employer promptly of any change to your or a family member's address, telephone number, or family status.

HIPAA Disclosure Policy

Delta Dental of Washington maintains a Compliance Program which includes an element involving maintaining privacy of information as it relates to the HIPAA Privacy & Security Rule and the Gram-Leach Bliley Act. As such we maintain a HIPAA Privacy member helpline for reporting of suspected privacy disclosures, provide members a copy of our privacy notice, track any unintended disclosures, and ensure the member rights are protected as identified by the Privacy Rule.

Policies and procedures are maintained and communicated to DDWA employees with reminders to maintain the privacy of our member's information. We also require all employees to participate in HIPAA Privacy & Security training through on-line education classes, email communications, and periodic auditing.